TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Baylor Medical Center at Irving

Respondent Name
Hartford Insurance Co

MFDR Tracking Number
M4-18-0722-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
November 16, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: No position statement submitted.

Amount in Dispute: $553.21

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Our investigation shows the following: ER visit is not authorized. Care is in relation to post op pain for an unapproved surgery."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 14, 2017	Outpatient Hospital Services	$553.21	$220.18

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the acute care hospital fee guideline for outpatient services.
3. 28 Texas Administrative Code §134.600 sets out guidelines for preauthorization of health care.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 197 – Payment denied/reduced for absence of precertification/authorization
   - W3 – Additional payment made on appeal/reconsideration

Issues

1. Did the Hartford raise a new defense pursuant to 28 Texas Administrative Code §133.307?
2. Are the insurance carrier's reasons for denial or reduction of payment supported?
3. What is the applicable rule for determining reimbursement for the disputed services?
4. Is the requestor entitled to additional reimbursement?

Findings

1. In its position statement, the Hartford states, "Care is in relation to post op pain for an unapproved surgery." Also included was "Notice of Disputed Issue(s) and Refusal to Pay Benefits."

   28 Texas Administrative Code §133.307(d)(2)(F) states, in relevant part, "The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review."

   Review of the submitted documentation finds that the Hartford failed to present a extent of injury denial to Baylor Medical Center at Irving in accordance with 28 Texas Administrative Code §133.240 prior to the date the request for medical fee dispute resolution (MFDR) was filed. The division concludes that this defense presented in the Hartford's position statement shall not be considered for review because this assertion constitutes a new defense pursuant to 28 Texas Administrative Code §133.307(d)(2)(F).

2. The insurance carrier denied disputed services with claim adjustment reason code 197 – "Payment denied/reduced for absence of precertification/authorization."

   28 Texas Administrative Code §134.600 (c) (1) states in pertinent part,

   The insurance carrier is liable for all reasonable and necessary medical costs relating to the health care:

   (1) listed in subsection (p) or (q) of this section only when the following situations occur:

   (2) an emergency, as defined in Chapter 133 of this title (relating to General Medical Provisions);

   Review of the submitted information finds that the submitted medical bill was for emergency room services. Therefore the insurance carrier's denial reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

3. This dispute regards outpatient hospital services with reimbursement subject to the division's *Hospital Facility Fee Guideline—Outpatient*, at 28 Texas Administrative Code §134.403, which requires the maximum allowable reimbursement (MAR) be calculated using the Medicare facility specific amount (including outlier payments) as determined by the applicable Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors, published annually in the Federal Register, with modifications as set forth in the rules.

   Rule §134.403(f)(1) requires that the sum of the Medicare facility specific amount and any applicable outlier payment be multiplied by 200 percent, unless a facility or surgical implant provider requests separate payment of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.

   Medicare's Outpatient Prospective Payment System (OPPS) assigns an Ambulatory Payment Classification (APC) for billed services based on procedure codes and supporting documentation. The APC determines the payment rate. Hospitals may be paid for more than one APC per encounter. Payment for ancillary items and for services without procedure codes is packaged into the APC payment. The Centers for Medicare and Medicaid Services (CMS) publishes quarterly lists of APC rates in the OPPS final rules, available from www.cms.gov.

   Reimbursement for the disputed services is calculated as follows:

- Procedure code 99282 has status indicator J2, denoting hospital, clinic or emergency room visits (including observation/critical care services) subject to composite payment if certain other services are billed in combination. The composite criteria is not met therefore, this is assigned APC 5022. The OPPS Addendum A rate is $111.47, which is multiplied by 60% for an unadjusted labor-related amount of $66.88, in turn multiplied by the facility wage index of 0.9794 for an adjusted labor amount of $65.50. The non-labor related portion is 40% of the APC rate, or $44.59. The sum of the labor and non-labor portions is $110.09. The cost of services does not exceed the fixed-dollar threshold of $3,825. The outlier payment is $0. The Medicare facility specific amount of $110.09 is multiplied by 200% for a MAR of $220.18.
- Procedure code J7512 has status indicator N, denoting packaged codes integral to the total service package with no separate payment; reimbursement is included in the payment for the primary services.

4. The total recommended reimbursement for the disputed services is $220.18. The insurance carrier has paid $0.00 leaving an amount due to the requestor of $220.18. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $220.18.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $220.18, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	December 29, 2017 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.